EMERGENCY ALLERGY HEALTH CARE PLAN

ALLERGY TO: ____

Student's
Name: ________________________________ D.O.B. __________ Teacher _______________

Asthmatic Yes ☐* No ☐ *High risk for severe reaction

Systems:	**Symptoms:**	**Give Checked Medication**:** To be determined by physician authorizing treatment	
•If a food allergen has been ingested or an insect bite has occurred, but no symptoms occur		☐ Epinephrine	☐ Antihistamine
•MOUTH	itching & swelling of the lips, tongue or mouth	☐ Epinephrine	☐ Antihistamine
•THROAT*	itching and/or a sense of tightness in the throat, hoarseness and hacking cough	☐ Epinephrine	☐ Antihistamine
•SKIN	hives, itchy rash and/or swelling about the face or extremities	☐ Epinephrine	☐ Antihistamine
•GUT	nausea, abdominal cramps, vomiting and/or diarrhea	☐ Epinephrine	☐ Antihistamine
•LUNG*	shortness of breath, repetitive coughing and/or wheezing	☐ Epinephrine	☐ Antihistamine
•HEART*	"thready" pulse, "passing-out", low blood pressure, fainting	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen ® EpiPen Jr. ® Twinject™ 0.3 mg Twinject™0.15 mg

Antihistamine: give Benedryl ____ mg ☐ liquid ☐ capsule po ________________
Medication/dose/route time

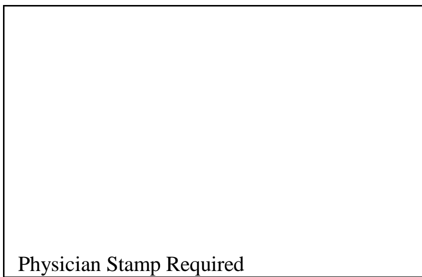
Other: give ____
Medication/dose/route

Is this a controlled substance? ☐**No** ☐**Yes** **Medication shall be administered from** ______________________ **to** ______________________.

Student may self administer this medication ☐**No** ☐**Yes**

Physician signature ____ **Parent signature** ____________________________________

Date ______________________ **School nurse signature** ____________________________________


Physician Stamp Required

1. Call 911 (or Rescue Squad: _________________). State that an allergic reaction has occurred and medication was administered.
2. Emergency contacts:
   Name/Relationship Phone Number(s)

   a. ____________________________________ 1.) __________________ 2.) __________________

   b. ____________________________________ 1.) __________________ 2.) __________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, YOUR SIGNATURE AUTHORIZES MEDICAL TREATMENT FOR YOUR CHILD & PERMISSION TO TRANSPORT TO A MEDICAL FACILITY.